

§ 403.322

(i) Comply with the requirements of paragraphs (b) (3) and (5) of § 403.320 regarding a detailed description of the methodology used to derive the expenditure amounts;

(ii) Include the data and assumptions set forth in paragraphs (b)(3) (i), (ii), (iii), (iv), and (v) of § 403.320; and

(iii) Include any assumption the State has adopted for establishing the number of Medicare and total base year outpatient services for each hospital.

(3) The State must provide a detailed explanation of the reasons for any difference between the data or assumptions used for the separate projections.

§ 403.322 Termination of agreements for Medicare recognition of State systems.

(a) *Termination of agreements.* (1) CMS may terminate any approved agreement if it finds, after the procedures described in this paragraph are followed that the State system does not satisfactorily meet the requirements of section 1886(c) of the Act or the regulations in this subpart. A termination must be effective on the last day of a calendar quarter.

(2) CMS will give the State reasonable notice of the proposed termination of an agreement and of the reasons for the termination at least 90 days before the effective date of the termination.

(3) CMS will give the State the opportunity to present evidence to refute the finding.

(4) CMS will issue a final notice of termination upon a final review and determination on the State's evidence.

(b) *Termination by State.* A State may voluntarily terminate a State system by giving CMS notice of its intent to terminate. A termination must be effective on the last day of a calendar quarter. The State must notify CMS of its intent to terminate at least 90 days before the effective date of the termination.

Subpart D [Reserved]

Subpart E—Beneficiary Counseling and Assistance Grants

SOURCE: 59 FR 51128, Oct. 7, 1994, unless otherwise noted.

42 CFR Ch. IV (10–1–11 Edition)

§ 403.500 Basis, scope, and definition.

(a) *Basis.* This subpart implements, in part, the provisions of section 4360 of Public Law 101–508 by establishing a minimum level of funding for grants made to States for the purpose of providing information, counseling, and assistance relating to obtaining adequate and appropriate health insurance coverage to individuals eligible to receive benefits under the Medicare program.

(b) *Scope of subpart.* This subpart sets forth the following:

(1) Conditions of eligibility for the grant.

(2) Minimum levels of funding for those States qualifying for the grants.

(3) Reporting requirements.

(c) *Definition.* For purposes of this subpart, the term “State” includes (except where otherwise indicated by the context) the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

§ 403.501 Eligibility for grants.

To be eligible for a grant under this subpart, the State must have an approved Medicare supplemental regulatory program under section 1882 of the Act and submit a timely application to CMS that meets the requirements of—

(a) Section 4360 of Public Law 101–508 (42 USC 1395b–4);

(b) This subpart; and

(c) The applicable solicitation for grant applications issued by CMS.

§ 403.502 Availability of grants.

CMS awards grants to States subject to availability of funds, and if applicable, subject to the satisfactory progress in the State's project during the preceding grant period. The criteria by which progress is evaluated and the performance standards for determining whether satisfactory progress has been made are specified in the terms and conditions included in the notice of grant award sent to each State. CMS advises each State as to when to make application, what to include in the application, and provides information as to the timing of the grant award and the duration of the grant award. CMS also provides an estimate of the

amount of funds that may be available to the State.

[71 FR 30290, May 26, 2006]

§ 403.504 Number and size of grants.

(a) *General.* For available grant funds, up to and including \$10,000,000, grants will be made to States according to the terms and formula in paragraphs (b) and (c) of this section. For any available grant funds in excess of \$10,000,000, distribution of grants will be at the discretion of CMS, and will be made according to criteria that CMS will communicate to the States via grant solicitation. CMS will provide information to each State as to what must be included in the application for grant funds. CMS awards the following type of grants:

(1) New program grants.

(2) Existing program enhancement grants.

(b) *Grant award.* Subject to the availability of funds, each eligible State that submits an acceptable application receives a grant that includes a fixed amount (minimum funding level) and a variable amount.

(1) A fixed portion is awarded to States in the following amounts:

(i) Each of the 50 States, \$75,000.

(ii) The District of Columbia, \$75,000.

(iii) Puerto Rico, \$75,000.

(iv) American Samoa, \$25,000.

(v) Guam, \$25,000.

(vi) The Virgin Islands, \$25,000.

(2) A variable portion, which is based on the number and location of Medicare beneficiaries residing in the State is awarded to each State. The variable amount a particular State receives is determined as set forth in paragraph (c) of this section.

(c) *Calculation of variable portion of the grant.* (1) CMS bases the variable portion of the grant on—

(i) The amount of available funds, and

(ii) A comparison of each State with the average of all of the States (except the State being compared) with respect to three factors that relate to the size of the State's Medicare population and where that population resides.

(2) The factors CMS uses to compare States' Medicare populations comprise separate components of the variable amount. These factors, and the extent

to which they each contribute to the variable amount, are as follows:

(i) Approximately 75 percent of the variable amount is based on the number of Medicare beneficiaries living in the State as a percentage of all Medicare beneficiaries nationwide.

(ii) Approximately 10 percent of the variable amount is based on the percentage of the State's total population who are Medicare beneficiaries.

(iii) Approximately 15 percent of the variable amount is based on the percentage of the State's Medicare beneficiaries that reside in rural areas ("rural areas" are defined as all areas not included within a Metropolitan Statistical Area).

(3) Based on the foregoing four factors (that is, the amount of available funds and the three comparative factors), CMS determines a variable rate for each participating State for each grant period.

(d) *Submission of revised budget.* A State that receives an amount of grant funds under this subpart that differs from the amount requested in the budget submitted with its application must submit a revised budget to CMS, along with its acceptance of the grant award, that reflects the amount awarded.

[59 FR 51128, Oct. 7, 1994, as amended at 65 FR 34986, June 1, 2000; 71 FR 30290, May 26, 2006]

§ 403.508 Limitations.

(a) *Use of grants.* Except as specified in paragraph (b) of this section, and in the terms and conditions in the notice of grant award, a State that receives a grant under this subpart may use the grant for any reasonable expenses for planning, developing, implementing, and/or operating the program for which the grant is made as described in the solicitation for application for the grant.

(b) *Maintenance of effort.* A State that receives a grant to supplement an existing program (that is, an existing program enhancement grant)—

(1) Must not use the grant to supplant funds for activities that were conducted immediately preceding the date of the initial award of a grant made under this subpart and funded through other sources (including in-kind contributions).